2011 DRAFTING REQUEST

Assembly Substitute Amendment (ASA-AB210)

Received: **09/16/2011**

Received By: **pkahler**

Wanted: **Soon**

Companion to LRB:

For: **Kevin Petersen (608) 266-3794**

By/Representing: **Jim Bowers and Dean Cady**

May Contact:

Drafter: **pkahler**

Subject: **Insurance - health**

Addl. Drafters:

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Petersen@legis.wisconsin.gov**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Modifications to federal health insurance reform

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 09/20/2011	csicilia 09/21/2011		_____ _____			
/P1	tdodge 09/29/2011	csicilia 09/30/2011	jfrantze 09/21/2011	_____ _____	sbasford 09/21/2011		
/P2			rschluet 09/30/2011	_____ _____	sbasford 09/30/2011		
/1	pkahler 10/06/2011	csicilia 10/06/2011	rschluet 10/06/2011	_____ _____	mbarman 10/06/2011	mbarman 10/06/2011	

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FE Sent For:

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FE Sent For: 1 cjs 10/6 KM 10/6

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/P1			jfrantze 09/21/2011		sbasford 09/21/2011		

FE Sent For: P2 cjs 9/30 9/30 11 4:30

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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler	/P1 cjs 9/21	9/21	pl 9/21			

FE Sent For:

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Dear Cody (Sen Vukmir) & Jim Bowers (Rep Petersen)
fr sub to AB 210:

✓(1) emergency rules ok but use reg procedure

✓(2) ~~Margie Kelley~~ Margit Kelley ask GMM
at Leg Council ← call her 6-9280
on p15 sub (3)

✓(3) delete (4)(6) re grandfathered plans

✓(4) add ~~all~~ all cont
→ any part incon repealed

✓ add as (5) Section 636.10
p 22

would not apply also
per Dean Cody provide that does not apply after Jan 1, 2020
– to put an end to monitoring reports and lawsuits)

✓(5) add new section

prohibits admin from creating exchange w/o legislative approval

TO: Jim Guidry, Legislative Liaison/Public Information Officer, OCI
FROM: David Riemer, Director, Community Advocates Public Policy Institute
DATE: June 9, 2011
RE: Comments on LRB-0267/P3

Sorry for the delay in responding! It's been a very busy ten days for me, so it took me longer than usual to reply.

I concur that LRB-0267/P3 is generally technical in nature and functions primarily to bring Wisconsin into compliance with existing insurance-related requirements of the Patient Protection and Affordable Care Act (PPACA).

I do, however, have several concerns about provisions that, while intended to be policy-neutral, (1) may contravene PPACA, (2) extend the power of the Commissioner of OCI beyond what is necessary to achieve compliance with PPACA's existing insurance-related requirements, or (3) appear to pre-empt the Legislature's policy-making role in areas outside of the scope of the proposed bill.

My specific concerns are as follows:

1. As I understand PPACA, a "small employer" means an employer with no more than 100 employees *unless* a state exercises the option—presumably through legislation—to redefine a "small employer" as one with no more than 50 employees. In other words, the PPACA assumption is that a "small employer" has up to 100 employees, but states are free for whatever *policy* reasons they may have to shrink the definition of "small employer" (for one, many, or all provisions of PPACA) to up to 50 employees. Whatever the wisdom of defining a small employer as a 1-100 employee firm or a 1-50 employee firm, PPACA makes it quite clear that down downsizing to 1-50 is a *policy* decision.

On p. 8 of LRB-0267/P3, Section 28, creating s. 625.02(2s), defines "a small employer" as "an employer that employed an average of at least one but not more than 50 employees...." Your cover memo explains that this language "[m]odifies the definition of small employer *for the purposes of rate review* to groups of 1-50...bypassing federal required definition of 1-100."

I have two major concerns about this provision:

• First, if the purpose of LRB-0267/P3 is simply to bring Wisconsin into technical compliance with the insurance-related provisions of PPACA, why does LRB-0267/P3 include in a technical compliance bill the important *policy* decision of downsizing the definition of "small employer" from 1-100 employees to 1-50 employees? There's no technical reason why a "small employer"—whether for rate review purposes or other purposes—must be a 1-50 employee firm. The choice of how small or big a "small employer" should be, for rate review purposes or any other PPACA purpose, is purely a *policy* issue. At the very least, OCI (and, for that matter, the Legislative Council and Legislative Reference Bureau) should make it clear to the Wisconsin Legislature that, whatever other elements of LRB-027/P3 are merely technical, *this* provision is <u>not</u> technical but is a significant *policy* choice. I would hope that OCI would also explain to the Legislature why it recommends such a policy choice, i.e., why it believes the pros outweigh the cons with respect to changing the federal presumption that a "small employer" is defined as a 1-100 employee firm.

•Second, despite the assurance in your cover memo—and, I'm sure OCI's intent--that this bill is meant to redefine "small employer" <u>only</u> for the narrow purpose of rate review by OCI and

for no other purpose under state law, the fact that that LRB-0267/P3's proposed s. 625.02(2s) definition of "small employer" as an employer with no more than 50 employees explicitly cross-references two broader sections of law—that is, both (a) the definition of "small group market" in the Public Health Service Act, and (b) this bill's definition of "health insurance coverage" (s.636.01(3)) in the definition section of the proposed new Chapter 363 on Health Insurance Reform--raises the question of whether the proposed s. 625.02(2s) inadvertently reduces the size of a "small employer" to those with no more than 50 employees for other or even all purposes of health insurance reform in Wisconsin. If proposed s. 625.02(2s) does indeed inadvertently downsize the definition of "small employer" in other areas of implementing PPACA, the effects would be profound, e.g., whether health care plans that offer "essential health benefits" as defined by PPACA must be offered only to firms with 1-50 employees or to those with 1-00 employees. Simply looking at the text on p. 8, I can't tell whether LRB-0267/P3 unintentionally has a much wider reach, in terms of downsizing the definition of "small employer," than OCI intends.

To avoid this problem, I recommend that OCI modify proposed s. 625.02(2s) to explicitly state that the downsizing of the definition of "small employer" is only for the purpose of rate review under s. [wherever rate review occurs in the bill]. For example, on line 5, you could delete "this subsection" and substitute "rate review only under s. [wherever rate review occurs in the bill]."

RESPONSE:

1) The current Wisconsin policy on rate review, as directed by the Wisconsin legislature, is that group health policies, including small group policies are not subject to rate review (see s. 625.03 (1m) (e). AB 210 makes the least possible change in this Wisconsin legislative policy by only extending rate review to 1-50 employee group policies, rather than 1-100 employee policies.

2) The current Wisconsin policy, as directed by the Wisconsin legislature, is to treat only group polices covering no more than 50 employees as "small group." See ch. 635, Stats.

3) The US DHHS guidance is that Wisconsin's current definition of small group will be applied for the purpose of the PPACA rate review process unless a state legislature enacts legislation to the contrary. (See 45 CFR 154.102) Therefore unless the Wisconsin legislature enacts a different definition the definition in ch. 635, Stats., will be applied by US DHHS. Hence a definition raising the number of employees to 100 would be a policy, not a technical, change.

4) There is no likelihood that AB 210 could be construed as limiting the Wisconsin legislature's right to make a future election under the PPACA regarding the definition of small group. The language of s. 625.02 (2s), is clear than this definition of small group is limited only to rate review. Moreover the proposed s. 636.01 (12), Stats., adopts a definition of employees up to 100 for the purposes of implementation of other PPACA insurance market requirements. Finally AB 210 explicitly reserves the right Wisconsin legislature under the PPACA to change that definition (see s. 636.10 (3), Stats.).

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2. On p. 9 of LRB-0267/P3, Section 33, amending s. 625.14, restates the current law requirement that copies of rate filings "may be obtained...upon payment of a reasonable charge therefore." This is current law, of course, but was probably written before the Internet made it possible and incredibly inexpensive to provide consumers (or anyone else) free copies of documents by placing them on the web. Why not just post on the OCI website all such filings as soon as they're filed?

RESPONSE:

OCI already posts health rate filing on its web site and will continue to do so.

3. On p. 12 of LRB-0267/P3, Section 42, creating s. 636.10(2), authorizes the OCI Commissioner to "promulgate any rule under this chapter or under [etc] as an emergency rule."

I understand the logic of allowing OCI to promulgate as emergency rules any rule that must be rushed into effect this summer to bring Wisconsin into compliance with existing insurance-related requirements of PPACA.

But the grant of power that s. 636.10(2) gives to the OCI Commissioner to use Wisconsin's emergency rule-making authority to promulgate *any* rule under Chapter 636 (etc.)--*no matter when* and *even if there's no exigent circumstance* to justify triggering the emergency rule-making provisions—is unwarranted.

The language of s. 636.10(2) would allow the OCI Commissioner to use emergency rule-making years or decades from now, even if there was ample opportunity to deploy the non-emergency rule-making provisions of Wisconsin's administrative rules statute. S.636.10 (2) also makes no distinction between rules or rule changes whose adoption is urgent vs. those that can take their time.

I strongly recommend that either this section be dropped entirely, or narrowly restricted to rules urgently needed to implement the new Chapter 636 etc. (a) during a 90-day period following the effective date of LRB-0267/P3 and (b) deemed essential by the OCI Commissioner to bring Wisconsin into compliance with PPACA.

All other rules should follow the normal Wisconsin rule-making process (which includes the "regular" process for promulgating emergency rules that's spelled out in Chapter 227.

RESPONSE:

1) The OCI emergency rulemaking provision allows OCI to timely respond to changes in federal regulations that implement the PPACA provisions. Absent this provision it will be difficult, if not impossible, to keep OCI rules in sync with the federal regulations. Finally any such rules must conform to the federal provisions that are implemented by state law through the proposed legislation.

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4. On p. 13 of LRB-0267/P3, Section 42, creating s. 636.10(3), states that "this state" reserves the right to elect...to "substitute '51 employees' for '101 employees' "under section 1304(b)(3) of PPACA.

As noted in my comments under #1, LRB-0267/P3 should not, as part of what's held out as a technical conforming piece of legislation, be making *policy* decisions about whether "small employer" means 1-50 or 1-100 employees. Such *policy* decisions should indeed be made later, during the Legislature's full discussion of PPACA. The proposed language here, by "reserving" the 1-50 vs. 1-100 decision to a subsequent "right to elect," is sound.

However, this proposed section of LRB-0267/P3 isn't clear about who can exercise the right of "this state" to make the 1-50 vs. 1-100 decision. Is "this state" the OCI Commissioner? Is "this state" the Governor? Or is "this state" the Legislature and Governor together, acting through the normal legislative process to enact a law?

The answer ought to be: the Legislature and Governor together, acting through the normal legislative process to enact a law.

To eliminate any question about what "this state" means, I recommend that proposed s. 636.10(3) be modified to make clear that it's the Legislature and Governor, acting together through the normal process of enacting and approving legislation, that "reserves the right to elect"...etc.

RESPONSE:

1) Since only the Wisconsin legislature may amend state law it is redundant to include the suggested statement.

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5. On p. 17 of LRB-0267/P3, Section 42, creating s. 636.25), which generally provides that "all" of a long list of requirements of the Public Health Service Act must be complied with by insurers, grandfathered health plans, and self-insured governmental health plans, nonetheless grants the OCI Commissioner the power to "provide otherwise by rule under s. 636.10."

In other words, in a law whose very purpose is to bring Wisconsin into *compliance* with existing insurance-related requirements of PPACA, an exception is carved out that allows OCI to promulgate rules that *violate* federal law.

Furthermore, (a) there's no limit on which of the named Public Health Service Act provisions that must be followed by insurers, grandfathered health plans, self-insured governmental health plans OCI could write a rule to contravene, (b) no requirement that OCI explain why it seeks to override federal law, and (c) no obligation on OCI's part to obtain legislative approval for a violation of federal law (which every legislator, in taking the oath of office, has sworn to uphold).

I strongly recommend that, in proposed s. 636.25, the entire clause in question (i.e., "and unless the commissioner provides otherwise by rule under s. 636.10") be removed.

Neither OCI nor any other state agency should be granted a statutory right—by rule or otherwise—to ignore, much less cause not to apply (i.e., violate)—*any* federal law. The Supremacy Clause of the U.S. Constitution (Article VI, Section 2) forbids it: "This Constitution, and the laws of the United States which shall be made in pursuance therefore...shall be the supreme law of the land." The Civil War settled the matter in 1865. If OCI or any other agency of state government wishes to cause a federal law not to apply, the only proper recourse is to go to federal court to try to strike down the federal law as a violation of one or another of the provisions of the U.S. Constitution. At the request of the Governor, the Attorney General of Wisconsin is indeed seeking to do precisely that with respect to PPACA. But as long as PPACA

remains valid law, no state statute should presume that a state official has the power to invalidate it by rule or otherwise.

RESPONSE:

1) The proposed legislation's exemption authority (which is subject, as always, to the legislative rulemaking oversight process) is constrained, as Mr. Reimer points out, because it can not supersede the PPACA. It is necessary for several reasons:

   a) Most important, it preserves OCI flexibility to manage the insurance market requirements under unforeseeable possible outcomes of the pending constitutional challenges to the PPACA.

   b) It serves the constitutional purpose of preserving Wisconsin's sovereign authority to disagree with a federal agency directive regarding implementation of PPACA in the unlikely event there is a justifiable dispute regarding the interpretation of the PPACA provisions.

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Kahler, Pam

From: Kelley, Margit
Sent: Monday, September 19, 2011 4:59 PM
To: Kahler, Pam
Subject: 2011 AB 210

Hi Pam,

I talked with Jim in Rep. Petersen's office, and he asked me to convey that the revisions to 2011 AB 210 should include:

- Adding "by legislation" to s. 636.10 (3).
- Clarifying that the severability provision of s. 636.35 would exempt the specified parts that were found unconstitutional or were repealed, if found unconstitutional or repealed only in part.

Thank you!

Margit Kelley
Wisconsin Legislative Council
608-266-9280
Margit.Kelley@legis.wi.gov

State of Wisconsin
2011 - 2012 LEGISLATURE

LRBs0181/?
PJK:.....

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

ASSEMBLY SUBSTITUTE AMENDMENT ,

TO 2011 ASSEMBLY BILL 210

AN ACT .; ~~relating to: ???~~

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

(END)

State of Wisconsin
2011 – 2012 LEGISLATURE

LRB-0267/2
PJK:cjs:ph

2011 ASSEMBLY BILL 210

July 29, 2011 – Introduced by Representative PETERSEN. Referred to Committee on Insurance.

AN ACT ***to repeal*** 609.755, 632.83, 632.835 and 632.885; ***to renumber*** 625.02 (1); ***to renumber and amend*** 625.03 (1m) (e); ***to amend*** 40.51 (8), 40.51 (8), 40.51 (8m), 40.51 (8m), 49.67 (3) (am) 2. b., 66.0137 (4), 66.0137 (4), 111.91 (2) (n), 111.91 (2) (nm), 111.91 (2) (s), 111.998 (2) (n), 111.998 (2) (s), 120.13 (2) (g), 120.13 (2) (g), 185.983 (1) (intro.), 185.983 (1) (intro.), 600.01 (2) (b), 601.31 (1) (Lp), 601.31 (1) (Lr), 601.42 (4), 609.655 (4) (b), 625.13 (1), 625.14, 632.76 (2) (ac) 1., 632.76 (2) (ac) 2., 632.76 (2) (ac) 3. (intro.) and 632.895 (15) (c) (intro.); and ***to create*** 601.465 (1m) (d), 625.02 (1h), 625.02 (1p), 625.02 (2f), 625.02 (2s), 625.03 (1m) (e) 2., 625.03 (1m) (e) 3., 625.13 (3), 632.76 (2) (ac) 4. and chapter 636 of the statutes; **relating to:** implementing health insurance reform, providing an exemption from emergency rule procedures, and granting rule-making authority.

Analysis by the Legislative Reference Bureau

This bill incorporates the health insurance coverage requirements of the federal Patient Protection and Affordable Care Act (PPACA) into the Wisconsin

statutes. The bill requires insurers to comply with PPACA provisions that went into effect for plan years beginning on or after March 23, 2010, relating to all of the following: 1) standards relating to benefits for mothers and newborns; 2) required coverage for reconstructive surgery following a mastectomy; and 3) coverage of a dependent student on a medically necessary leave of absence. The bill requires insurers to comply with PPACA provisions that went into effect for plan years beginning on or after September 23, 2010, relating to all of the following: 1) prohibiting annual or lifetime limits; 2) prohibiting coverage rescissions; 3) prohibiting preexisting condition exclusions for individuals under age 19; 4) coverage of certain preventive health services without cost–sharing; 5) extension of coverage to dependents up to age 26; 6) the provision of additional information; 7) giving plan enrollees choice as to a primary care provider; and 8) coverage of emergency services without prior authorization. In addition, the bill requires insurers to comply with PPACA provisions for plan years beginning on or after March 23, 2012, relating to all of the following: 1) the development and use of uniform explanation of coverage documents and standardized definitions; and 2) requirements for ensuring the quality of care. The bill also requires insurers to comply with the PPACA requirement to file a report for each plan year concerning the ratio of incurred loss, plus loss adjustment expense, to earned premiums and to provide a rebate to enrollees under certain circumstances. Under PPACA, the provisions apply to insurers offering medical care benefits under any hospital or medical service policy or plan contract.

A health care policy or plan that was in effect when PPACA was enacted is called a grandfathered health plan. The bill specifically requires a grandfathered health plan to comply, when the grandfathered health plan is renewed, with the following PPACA provisions: 1) coverage of a dependent student on a medically necessary leave of absence; 2) coverage of certain preventive health services without cost–sharing; 3) coverage of emergency services without prior authorization; and 4) at renewal on or after March 23, 2012, requirements for ensuring the quality of care. The bill provides that the additional requirements under the bill with which insurers must comply apply to grandfathered health plans only with respect to those requirements that apply to grandfathered health plans under PPACA.

Current law requires health insurers to cover emergency services without prior authorization, breast reconstruction after a mastectomy, dependent coverage of a student while on a medically necessary leave of absence, and colorectal screening. These coverage provisions are consistent with, and therefore duplicative of, the relevant PPACA requirements and are not repealed in the bill. Current law also requires health insurers to provide coverage of a dependent up to age 27, or up to any age if the dependent is a student and had to leave school previously because he or she was called to active duty in the armed forces. PPACA requires coverage of a dependent up to age 26 and has no additional requirement related to a student previously called to active duty. Because of this inconsistency, the current law dependent coverage provision is repealed in the bill. The bill specifies that, if PPACA is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in its entirety and unenforceable in this state, after all appeals have

been exhausted or the time for appeal has expired, insurers are exempt from the PPACA coverage requirements incorporated into the bill, with the exception of the provision related to dependent coverage. Thus, if PPACA were found unconstitutional, in addition to the dependent coverage requirement, insurers would be subject to the coverage requirements in current law that are consistent with PPACA and that have not been repealed in the bill.

Under current law, a health insurer must have an internal grievance procedure and an independent review procedure whereby an insured person may appeal certain types of coverage denials to an independent review organization. The statutes set out criteria for both procedures and provide for certification of independent review organizations by the commissioner of insurance (commissioner). The bill repeals these provisions and requires the commissioner to establish standards by rule for both internal and external appeals that are consistent with requirements under PPACA. The requirements for internal appeals apply to all group and individual health insurance policies, grandfathered health plans, policies providing limited–scope dental or vision benefits, and hospital or fixed indemnity policies. The requirements for external appeals apply to all group and individual health insurance policies, grandfathered health plans, hospital or fixed indemnity policies, and Medicare supplement or replacement polices, excluding Medicare advantage plans. An independent review organization performing external appeals must be certified by the commissioner, who may revoke, suspend, or limit the certification or refuse to recertify under specified conditions. An independent review organization must have a quality assurance mechanism to ensure timely and independent reviews and may charge reasonable fees, which must be approved by the commissioner. The commissioner has authority to examine and audit an independent review organization's books and records. A decision of an independent review organization is binding on the insured and the insurer. An independent review organization is immune from any liability that may result from an independent review determination, and an insurer is not liable for any damages attributable to actions taken in compliance with an independent review organization determination.

Under current law, rates for insurance must be filed with the commissioner within 30 days after they become effective, and the commissioner may disapprove a rate after it has been filed. Certain types of insurance, including group and blanket accident and sickness insurance, are exempt from the rating requirement provisions, including the requirement to file rates. The bill provides that, beginning on September 1, 2011, group health insurance offered to employers with not more than 50 employees (small employer health insurance) and group and blanket accident and sickness insurance offered in the individual market are not exempt from the rating requirement provisions. In addition, the bill requires that rates for individual health insurance, small employer health insurance, and group and blanket accident and sickness insurance offered in the individual market be filed with the commissioner before, rather than after, they become effective.

For ~~further~~ information see the ***state and local*** ~~fiscal~~ estimate, ~~which~~ will be printed as an ~~appendix~~ to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, ~~632.83, 632.835,~~ 632.85, 632.853, 632.855, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896 and, so far as applicable, ch. 636.

SECTION 2. 40.51 (8) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.85, 632.853, 632.855, 632.87 (3) to (6), ~~632.885,~~ 632.89, 632.895 (5m) and (8) to (17), and 632.896 and, so far as applicable, ch. 636.

SECTION 3. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, ~~632.83, 632.835,~~ 632.85, 632.853, 632.855, 632.885, 632.89, and 632.895 (11) to (17) and, so far as applicable, ch. 636.

SECTION 4. 40.51 (8m) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.85, 632.853, 632.855, ~~632.885,~~ 632.89, and 632.895 (11) to (17) and, so far as applicable, ch. 636.

SECTION 5. 49.67 (3) (am) 2. b. of the statutes, as affected by 2011 Wisconsin Act 32, is amended to read:

49.67 **(3)** (am) 2. b. If the applicant is under 26 years of age, notice that he or she may be eligible for coverage as a dependent under his or her parent's health care plan in accordance with s. ~~632.885~~ 636.25 (1) (h) or (3) (b), and that his or her parent's plan must include coverage for services that are not covered under the plan under this section.

SECTION 6. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4) and, so far as applicable, ch. 636.

SECTION 7. 66.0137 (4) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self–insured basis, the self–insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2),

632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), ~~632.885,~~ 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4) and, so far as applicable, ch. 636.

SECTION 8. 111.91 (2) (n) of the statutes is amended to read:

111.91 **(2)** (n) The provision to employees of the health insurance coverage required under s. 632.895 (11) to (14), (16), ~~and~~ (16m), and (17) and, so far as applicable, s. 636.25.

SECTION 9. 111.91 (2) (nm) of the statutes is amended to read:

111.91 **(2)** (nm) The requirements related to ~~providing coverage for a dependent under s. 632.885 and to~~ continuing coverage for a dependent student on a medical leave of absence under s. 632.895 (15).

SECTION 10. 111.91 (2) (s) of the statutes is amended to read:

111.91 **(2)** (s) The requirements related to internal ~~grievance procedures under s. 632.83 and independent review~~ and external appeals of certain health benefit plan determinations established under s. ~~632.835~~ 636.12.

SECTION 11. 111.998 (2) (n) of the statutes is amended to read:

111.998 **(2)** (n) The provision to employees of the health insurance coverage required under s. 632.895 (11) to (14) and, so far as applicable, s. 636.25.

SECTION 12. 111.998 (2) (s) of the statutes is amended to read:

111.998 **(2)** (s) The requirements related to internal ~~grievance procedures under s. 632.83 and independent review~~ and external appeals of certain health benefit plan determinations established under s. ~~632.835~~ 636.12.

SECTION 13. 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3),

632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4) and, so far as applicable, ch. 636.

SECTION 14. 120.13 (2) (g) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

120.13 **(2)** (g) Every self–insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.87 (4), (5), and (6), ~~632.885,~~ 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4) and, so far as applicable, ch. 636.

SECTION 15. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2), (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 625, 630, 635, 636, 645, and 646, but the sponsoring association shall:

SECTION 16. 185.983 (1) (intro.) of the statutes, as affected by 2011 Wisconsin Act .... (this act), is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.87 (2), (2m), (3), (4), (5), and (6), ~~632.885,~~ 632.89, 632.895 (5)

and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 625, 630, 635, 636, 645, and 646, but the sponsoring association shall:

SECTION 17. 600.01 (2) (b) of the statutes is amended to read:

600.01 **(2)** (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to 632.749~~, 632.83 or 632.835~~ or 636.12 or ch. 633 or 635.

SECTION 18. 601.31 (1) (Lp) of the statutes is amended to read:

601.31 **(1)** (Lp) For certifying as an independent review organization under s. ~~632.835~~ 636.15 (1) (a), $400.

SECTION 19. 601.31 (1) (Lr) of the statutes is amended to read:

601.31 **(1)** (Lr) For each biennial recertification as an independent review organization under s. ~~632.835~~ 636.15 (1) (a), $100.

SECTION 20. 601.42 (4) of the statutes is amended to read:

601.42 **(4)** REPLIES. Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), any independent review organization certified or recertified under s. ~~632.835 (4)~~ 636.15 (1) (a) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

SECTION 21. 601.465 (1m) (d) of the statutes is created to read:

601.465 **(1m)** (d) Information contained in individual or small group health insurance rate and supplementary rate information filed under ch. 625 that the office determines is proprietary.

SECTION 22. 609.655 (4) (b) of the statutes is amended to read:

609.655 **(4)** (b) Upon completion of the review under par. (a), the medical director of the defined network plan shall determine whether the policy or certificate will provide coverage of any further treatment for the dependent student's nervous or mental disorder or alcoholism or other drug abuse problems that is provided by a provider located in reasonably close proximity to the school in which the student is enrolled. If the dependent student disputes the medical director's determination, the dependent student may submit a written grievance under the defined network plan's internal grievance procedure established under s. ~~632.83~~ 636.12.

SECTION 23. 609.755 of the statutes is repealed.

SECTION 24. 625.02 (1) of the statutes is renumbered 625.02 (1m).

SECTION 25. 625.02 (1h) of the statutes is created to read:

625.02 **(1h)** "Individual health insurance coverage" has the meaning given in s. 636.01 (4).

SECTION 26. 625.02 (1p) of the statutes is created to read:

625.02 **(1p)** "Public Health Service Act" has the meaning given in s. 636.01 (9).

SECTION 27. 625.02 (2f) of the statutes is created to read:

625.02 **(2f)** "Secretary" means the secretary of the federal department of health and human services.

SECTION 28. 625.02 (2s) of the statutes is created to read:

625.02 **(2s)** "Small employer health insurance" means health insurance coverage as defined in s. 636.01 (3) that is offered in the small group market as

defined in section 2791 (e) (5) of the Public Health Service Act (42 USC 300gg–91 (e) (5)). For purposes of this subsection, a small employer is an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and that employs at least one employee on the first day of the plan year.

SECTION 29. 625.03 (1m) (e) of the statutes is renumbered 625.03 (1m) (e) (intro.) and amended to read:

625.03 **(1m)** (e) (intro.) Group and blanket accident and sickness insurance ~~other than credit~~, except for the following:

1. Credit accident and sickness insurance.

SECTION 30. 625.03 (1m) (e) 2. of the statutes is created to read:

625.03 **(1m)** (e) 2. Subject to s. 636.35, on and after September 1, 2011, small employer health insurance, unless the commissioner provides otherwise by rule, including emergency rule as provided in s. 636.10 (2).

SECTION 31. 625.03 (1m) (e) 3. of the statutes is created to read:

625.03 **(1m)** (e) 3. Subject to s. 636.35, on and after September 1, 2011, group and blanket accident and sickness insurance offered in the individual market, as defined in s. 636.01 (5), unless the commissioner provides otherwise by rule, including emergency rule as provided in s. 636.10 (2).

SECTION 32. 625.13 (1) of the statutes is amended to read:

625.13 **(1)** FILING PROCEDURE. Except as provided in ~~sub.~~ subs. (2) and (3), every authorized insurer and every rate service organization licensed under s. 625.31 which has been designated by any insurer for the filing of rates under s. 625.15 (2) shall file with the commissioner all rates and supplementary rate information and

all changes and amendments thereof made by it for use in this state within 30 days after they become effective.

SECTION 33. 625.13 (3) of the statutes is created to read:

625.13 **(3)** INDIVIDUAL AND SMALL EMPLOYER HEALTH INSURANCE. Subject to s. 636.35, on and after September 1, 2011, unless the commissioner provides otherwise by rule, including emergency rule as provided in s. 636.10 (2), for individual health insurance coverage, group and blanket accident and sickness insurance offered in the individual market, or small employer health insurance an insurer, or a rate service organization licensed under s. 625.31 that has been designated by the insurer for the filing of rates under s. 625.15 (2), shall file with the commissioner all rates and supplementary rate information, and all changes and amendments to the information, before they become effective.

SECTION 34. 625.14 of the statutes is amended to read:

625.14 Filings open to inspection. ~~Each~~ Subject to s. 601.465 (1m) (d), each filing and any supporting information filed under this chapter shall, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

SECTION 35. 632.76 (2) (ac) 1. of the statutes is amended to read:

632.76 **(2)** (ac) 1. Notwithstanding par. (a) and except as provided in subd. 4., no claim or loss incurred or disability commencing after 12 months from the date of issue of an individual disability insurance policy, as defined in s. 632.895 (1) (a), may be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description by a provision effective on the date of the loss.

SECTION 36. 632.76 (2) (ac) 2. of the statutes is amended to read:

632.76 **(2)** (ac) 2. Except as provided in ~~subd.~~ subds. 3. and 4., an individual disability insurance policy, as defined in s. 632.895 (1) (a), other than a short–term policy subject to s. 632.7495 (4) and (5), may not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months before the effective date of coverage.

SECTION 37. 632.76 (2) (ac) 3. (intro.) of the statutes is amended to read:

632.76 **(2)** (ac) 3. (intro.) Except as provided in subd. 4. and except as the commissioner provides by rule under s. 632.7495 (5), all of the following apply to an individual disability insurance policy that is a short–term policy subject to s. 632.7495 (4) and (5):

SECTION 38. 632.76 (2) (ac) 4. of the statutes is created to read:

632.76 **(2)** (ac) 4. Subdivisions 1., 2., and 3. do not apply to an individual disability insurance policy, as defined in s. 632.895 (1) (a), issued on or after September 23, 2010, and before January 1, 2014, that covers an individual who is under 19 years of age, with respect to coverage of that individual. Section 636.25 (1) (f) applies to such a policy with respect to coverage of that individual.

SECTION 39. 632.83 of the statutes is repealed.

SECTION 40. 632.835 of the statutes is repealed.

SECTION 41. 632.885 of the statutes, as affected by 2011 Wisconsin Act 32, is repealed.

SECTION 42. 632.895 (15) (c) (intro.) of the statutes is amended to read:

632.895 **(15)** (c) (intro.) ~~A~~ Except as otherwise required under s. 636.25 (1) (c), (2) (a), or (3) (a), a policy or plan is required to continue coverage under par. (a) only until any of the following occurs:

SECTION 43. Chapter 636 of the statutes is created to read:

CHAPTER 636

HEALTH INSURANCE REFORM

636.01 Definitions. In this chapter, unless the context requires otherwise:

(1) "Defined network plan" has the meaning given in s. 609.01 (1b).

(2) "Grandfathered health plan" has the meaning given in section 1251 (e) of the Patient Protection and Affordable Care Act.

(3) "Health insurance coverage" has the meaning given in section 2791 (b) (1) of the Public Health Service Act (42 USC 300gg–91 (b) (1)). "Health insurance coverage" includes coverage issued by an insurer and insurance that is a group health plan, as defined in section 2791 (a) (1) of the Public Health Service Act (42 USC 300gg–91 (a) (1)). "Health insurance coverage" does not include excepted benefits that are excluded under section 2722 (b) or (c) of the Public Health Service Act (42 USC 300gg–21 (b) or (c)).

(4) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market. "Individual health insurance coverage" does not include short–term limited duration insurance.

(5) "Individual market" has the meaning given in section 1304 (a) (2) of the Patient Protection and Affordable Care Act.

(6) "Limited–scope dental or vision benefits" means limited–scope dental or vision benefits provided under a separate policy, certificate, or contract of insurance or plan, or otherwise not provided as an integral part of the policy, certificate, or contract of insurance or plan.

(7) "Patient Protection and Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111–148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111–152.

(8) "Preexisting condition exclusion denial determination" means a determination by or on behalf of an insurer that issues a health benefit plan denying or terminating treatment or payment for treatment on the basis of a preexisting condition exclusion, as defined in s. 632.745 (23).

(9) "Public Health Service Act" means the federal Public Health Service Act of 1944, as amended, including by the Patient Protection and Affordable Care Act (42 USC 300gg et seq.).

(10) "Secretary" means the secretary of the federal department of health and human services.

(11) "Self–insured governmental health plan" means a self–insured health plan of the state or a county, city, village, town, or school district.

(12) "Small employer health insurance" means health insurance coverage offered in the small group market as defined in section 2791 (e) (5) of the Public Health Service Act (42 USC 300gg–91 (e) (5)) and section 1304 (a) (3) of the Patient Protection and Affordable Care Act, as applied by the secretary's regulation for the purposes of section 2718 of the Public Health Service Act (42 USC 300gg–18). For purposes of this definition, in section 1304 (a) (3) of the Patient Protection and Affordable Care Act, "small employer" has the meaning given in section 1304 (b) (2) of that act.

636.10 General provisions. (1) AUTHORITY IS ADDITIONAL. The commissioner's authority under this chapter is in addition to any authority otherwise provided under chs. 600 to 635 and chs. 644 to 646. The commissioner may

by rule establish standards for compliance with this chapter. The commissioner may establish reporting requirements for the purpose of monitoring or enforcing compliance with this chapter and rules adopted under this chapter.

(2) EMERGENCY RULE–MAKING. Using the procedure under s. 227.24, the commissioner may promulgate any rule under this chapter or under s. 625.03 (1m) (e) 2. or 3. or 625.13 (3) as an emergency rule. Notwithstanding s. 227.24 (1) (c), any emergency rule promulgated under this subsection may remain in effect for up to one year and, in addition, may be extended under s. 227.24 (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

(3) EMPLOYER SIZE ELECTION. Notwithstanding s. 636.01 (12), this state reserves the right to elect, as permitted under section 1304 (b) (3) of the Patient Protection and Affordable Care Act, to substitute "51 employees" for "101 employees" and "50 employees" for "100 employees," after the effective date of this subsection .... [LRB inserts date], for any purpose permitted under the Public Health Service Act.

636.12 Internal and external appeals. (1) ESTABLISHING STANDARDS. Notwithstanding any inconsistent provision of chs. 600 to 635 or chs. 644 to 646, the commissioner shall by rule do all of the following:

(a) Establish standards for internal appeals that, at a minimum, include consumer protections consistent with section 2719 (a) of the Public Health Service Act (42 USC 300gg–19 (a)), and require an insurer to comply with the standards. The commissioner shall apply the standards established under this paragraph to all of the following:

1. Group and individual health insurance coverage subject to section 2719 (a) of the Public Health Service Act (42 USC 300gg–19 (a)).

2. Grandfathered health plans that otherwise would be subject to section 2719 (a) of the Public Health Service Act (42 USC 300gg–19 (a)).

3. A policy, certificate, or contract that provides only limited–scope dental or vision benefits.

4. Coverage specified in s. 632.745 (11) (b) 10.

(b) Establish standards for external appeals, including standards for appealing a preexisting condition exclusion denial determination or the rescission of a policy or certificate, and require an insurer to comply with the standards. The commissioner shall adopt standards under this paragraph that comply either with section 2719 (b) (1) of the Public Health Service Act (42 USC 300gg–19 (b) (1)) or with the standards established by the secretary under section 2719 (b) (2) of the Public Health Service Act (42 USC 300gg–19 (b) (2)). The commissioner shall apply the external appeal standards established under this paragraph to all of the following:

1. Group and individual health insurance coverage subject to section 2719 (b) of the Public Health Service Act (42 USC 300gg–19 (b)).

2. Grandfathered health plans.

3. Coverage specified in s. 632.745 (11) (b) 10.

4. Coverage specified in s. 632.745 (11) (b) 11., including Medicare supplement or replacement policies, but excluding Medicare advantage plans.

(c) Establish standards for independent review organizations.

(2) COMPLIANCE REQUIRED. An insurer and an independent review organization shall comply with the rules promulgated under this chapter.

636.15 Independent review organizations. (1) CERTIFICATION. (a) An independent review organization may not perform a review for purposes of the external appeals process established in accordance with standards promulgated under s. 636.12 (1) (b) unless the organization is certified by the commissioner. Unless the commissioner provides otherwise by rule, only an independent review organization that is accredited by a nationally recognized private accreditation organization may be certified under this paragraph. An independent review organization must demonstrate to the satisfaction of the commissioner that it is unbiased and does not have a conflict of interest, as defined by the commissioner by rule. An organization certified under this paragraph must be recertified on a biennial basis.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under s. 636.12 (1) (c).

(c) An independent review organization that was certified or recertified by the commissioner under s. 632.835, 2009 stats., and whose certification is in effect on the effective date of this paragraph .... [LRB inserts date], shall be considered to have been certified under par. (a), and its certification shall remain in effect until the certification expires or it is revoked or suspended under sub. (5) or s. 227.51 (3).

(2) QUALITY ASSURANCE MECHANISM. An independent review organization shall have in operation a quality assurance mechanism to ensure the timeliness and quality of the independent reviews, the qualifications and independence of the

clinical peer reviewers, and the confidentiality of the medical records and review materials.

(3) REASONABLE FEES. An independent review organization shall establish reasonable fees that it will charge for independent reviews and shall submit its fee schedule to the commissioner for a determination of reasonableness and for prior approval. An independent review organization may not change any fees approved by the commissioner more than once per year and shall submit any proposed fee changes to the commissioner for prior approval.

(4) EXAMINATIONS AND AUDITS. The commissioner may examine, audit, or accept an audit of, the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (1), (3), (4), and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(5) REVOCATION, SUSPENSION, REFUSAL TO RECERTIFY. The commissioner may revoke, suspend, or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified or has violated a statute, or a rule promulgated, under chs. 600 to 646 or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(6) DECISION IS BINDING. Unless otherwise required by the standards under section 2719 (b) of the Public Health Service Act (42 USC 300gg–19 (b)), a decision of an independent review organization is binding on the insured and the insurer.

(7) IMMUNITY FROM LIABILITY. (a) An independent review organization that is certified under this section is immune from any civil or criminal liability that may result because of an independent review determination made under the rules promulgated under this chapter. An employee, agent, or contractor of a certified independent review organization is immune from any civil or criminal liability for any act or omission done in good faith within the scope of his or her powers and duties under the rules promulgated under this chapter.

(b) An insurer is not liable to any person for damages attributable to the insurer's actions taken in compliance with any decision regarding a determination rendered by a certified independent review organization.

(8) INSURED'S RIGHT TO COMMENCE CIVIL PROCEEDING. Nothing in this section affects an insured's right to commence a civil proceeding relating to a matter that may be appealed under the standards established under s. 636.12 (1).

636.18 Rebate and report requirement. Subject to s. 636.35, an insurer offering small employer health insurance or individual health insurance coverage shall comply with section 2718 of the Public Health Service Act (42 USC 300gg–18) and shall file the report required under section 2718 (a) of that act (42 USC 300gg–18 (a)) with the commissioner no later than the date required for filing with the secretary.

636.25 Implementing health insurance coverage provisions. Subject to s. 636.35, notwithstanding any inconsistent provision in chs. 600 to 635 or chs. 644

to 646, and unless the commissioner provides otherwise by rule under s. 636.10, all of the following apply:

(1) INSURERS. An insurer shall comply with all of the following provisions of the Public Health Service Act:

(a) *Standards relating to benefits for mothers and newborns.* Section 2725 (42 USC 300gg–25).

(b) *Required coverage for reconstructive surgery following mastectomies.* Section 2727 (42 USC 300gg–27).

(c) *Coverage of dependent students on medically necessary leave of absence.* Section 2728 (42 USC 300gg–28).

(d) *No lifetime limit or annual limits.* Section 2711 (42 USC 300gg–11).

(e) *Prohibition on rescissions.* Section 2712 (42 USC 300gg–12).

(f) *Prohibition on preexisting condition exclusions for under age 19.* Section 2704 (42 USC 300gg–04), but only for enrollees who are under 19 years of age.

(g) *Coverage of preventive health services.* Section 2713 (42 USC 300gg–13).

(h) *Extension of dependent coverage.* Section 2714 (42 USC 300gg–14).

(i) *Provision of additional information.* Section 2715A (42 USC 300gg–15a).

(j) *Patient protections; choice of health care professional.* Section 2719A (a) (42 USC 300gg–19a (a)).

(k) *Patient protections; coverage of emergency services.* Section 2719A (b) (42 USC 300gg–19a (b)). In addition, an insurer also shall comply with s. 632.85 and an insurer that provides coverage under a defined network plan also shall comply with s. 609.22 (6).

(2) GRANDFATHERED HEALTH PLANS. A grandfathered health plan shall comply with all of the following provisions of the Public Health Service Act:

(a) *Coverage of dependent students on medically necessary leave of absence.* Section 2728 (42 USC 300gg–28).

(b) *Coverage of preventive health services.* Section 2713 (42 USC 300gg–13).

(c) *Patient protections; coverage of emergency services.* Section 2719A (b) (42 USC 300gg–19a (b)).

(3) SELF-INSURED GOVERNMENTAL HEALTH PLANS. A self–insured governmental health plan shall comply with all of the following provisions of the Public Health Service Act:

(a) *Coverage of dependent students on medically necessary leave of absence.* Section 2728 (42 USC 300gg–28).

(b) *Extension of dependent coverage.* Section 2714 (42 USC 300gg–14).

(c) *Patient protections; coverage of emergency services.* Section 2719A (b) (42 USC 300gg–19a (b)). In addition, a self–insured governmental health plan also shall comply with s. 632.85.

(4) ADDITIONAL REQUIREMENTS. With respect to health insurance coverage that is issued or renewed on or after March 23, 2012, all of the following apply:

(a) *Insurers.* An insurer shall comply with all of the following provisions of the Public Health Service Act:

1. Uniform explanation of coverage documents and standardization of definitions. Section 2715 (42 USC 300gg–15).

2. Ensuring the quality of care. Section 2717 (42 USC 300gg–17).

(b) *Grandfathered health plans.* A grandfathered health plan shall comply with section 2717 of the Public Health Service Act (42 USC 300gg–17), relating to ensuring the quality of care.

(5) APPLICATION OF SECTION TO GRANDFATHERED HEALTH PLANS. In addition to subs. (2) and (4) (b), this section applies to a grandfathered health plan, but only with respect to those provisions of the Public Health Service Act referred to in this section that apply to a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act.

636.35 Applicability if federal law found unconstitutional. If the Patient Protection and Affordable Care Act is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in its entirety or in part and unenforceable in this state, and if all appeals are exhausted or the time for appeal expires, insurers and self–insured governmental health plans are exempt from all of the following provisions on and after the first day of the 3rd month beginning after the date on which all appeals are exhausted or the time for appeal expires:

(a) Section 625.13 (3).

(b) Section 636.18.

(c) Section 636.25, except for s. 636.25 (1) (h) and (3) (b).

(d) Chapter 625 with respect to small employer health insurance and group and blanket accident and sickness insurance offered in the individual market.

SECTION 44. Initial applicability.

(1) MISCELLANEOUS COVERAGE REQUIREMENTS. The treatment of sections 40.51 (8) (by SECTION 2) and (8m) (by SECTION 4), 49.67 (3) (am) 2. b., 66.0137 (4) (by SECTION 7), 111.91 (2) (n) and (nm), 111.998 (2) (n), 120.13 (2) (g) (by SECTION 14), 185.983 (1) (intro.) (by SECTION 16), 609.755, 632.76 (2) (ac) 1., 2., 3. (intro.), and 4., 632.885, 632.895 (15) (c) (intro.), and 636.25 (1), (2), (3), and (5) of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b), (c), and (d), disability insurance policies that are newly issued, and self–insured governmental or school district health plans that are newly established on the effective date of this paragraph.

(b) Except as provided in paragraph (d), disability insurance policies, and self–insured governmental or school district health plans, that are grandfathered health plans, as defined in section 636.01 (2) of the statutes, as created by this act, that are renewed, extended, or modified on the effective date of this paragraph.

(c) Except as provided in paragraph (d), disability insurance policies, and self–insured governmental or school district health plans, covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are newly issued or newly established on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(d) Disability insurance policies, and self–insured governmental or school district health plans, that are grandfathered health plans, as defined in section 636.01 (2) of the statutes, as created by this act, that cover employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act, and that are renewed, extended, or modified on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(2) INTERNAL AND EXTERNAL APPEALS. The treatment of sections 40.51 (8) (by SECTION 1) (with respect to internal and external review procedures), 40.51 (8m) (by SECTION 3) (with respect to internal and external review procedures), 66.0137 (4) (by SECTION 6) (with respect to internal and external review procedures), 111.91 (2) (s), 111.998 (2) (s), 120.13 (2) (g) (by SECTION 13) (with respect to internal and external review procedures), 185.983 (1) (intro.) (by SECTION 15) (with respect to internal and external review procedures), 600.01 (2) (b), 609.655 (4) (b), 632.83, 632.835, 636.12, and 636.15 of the statutes first applies to appeals filed on the effective date of this subsection.

SECTION 45. Effective dates. This act takes effect on the day after publication, except as follows:

(1) HEALTH INSURANCE COVERAGE PROVISIONS. The treatment of sections 40.51 (8) (by SECTION 2) and (8m) (by SECTION 4), 49.67 (3) (am) 2. b., 66.0137 (4) (by SECTION 7), 111.91 (2) (n) and (nm), 111.998 (2) (n), 120.13 (2) (g) (by SECTION 14), 185.983 (1) (intro.) (by SECTION 16), 609.755, 632.76 (2) (ac) 1., 2., 3. (intro.), and 4., 632.885, 632.895 (15) (c) (intro.), 636.25, and 636.35 of the statutes and SECTION 44 (1) of this act take effect on the first day of the 6th month beginning after publication.

(2) INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE RATING. The treatment of sections 601.465 (1m) (d), 625.02 (1), (1h), (1p), (2f), and (2s), 625.13 (1) and (3), and 625.14 of the statutes, the renumbering and amendment of section 625.03 (1m) (e) of the statutes, and the creation of section 625.03 (1m) (e) 2. and 3. of the statutes take effect on September 1, 2011, or on the day after publication, whichever is later.

(END)

D-note

2011-2012 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

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INSERT A

This substitute amendment differs from 2011 Assembly Bill 210 (the bill) in the following respects:

1. In the bill, the Office of the Commissioner of Insurance (OCI) may promulgate any rule related to the provisions created in the bill as an emergency rule and is not required to provide evidence that promulgating the rule as an emergency rule is necessary for the preservation of public peace, health, safety, or welfare and is not required to provide a finding of emergency. The substitute amendment removes this exception so that OCI, in promulgating an emergency rule, would be required to provide evidence that the emergency rule is necessary for the preservation of public peace, health, safety, or welfare and required to provide a finding of emergency.

2. Under the bill, grandfathered plans renewed on or after March 23, 2012, are required to comply with the federal Patient Protection and Affordable Care Act (PPACA) relating to requirements for ensuring the quality of care. The substitute amendment removes this requirement for grandfathered plans.

3. PPACA defines a small employer as one that employs not more than 100 employees, however, states are allowed to elect to define a small employer, for plan years beginning before January 1, 2016, as an employer with not more than 50 employees. The bill defines a small employer for purposes of the PPACA requirements as an employer with not more than 100 employees but specifically reserves the right to elect to substitute 50 for 100 for the definition of small employer. The substitute amendment provides that this election must be done through legislation.

4. The bill provides that if PPACA is found unconstitutional in its entirety and all appeals are exhausted or the time for appeal expires, insurers and self-insured governmental health plans are exempt from a number of provisions in the bill. The substitute amendment adds that, if PPACA is found unconstitutional in its entirety, the powers of OCI with respect to promulgating rules for, and enforcing, the PPACA coverage requirements, as well as any rules or requirements already established, do not apply. The substitute amendment also provides that if PPACA is found unconstitutional in part, or if any of its provisions are repealed, insurers and self-insured governmental health plans are exempt from those provisions, and the powers of OCI with respect to promulgating rules for, and enforcing, those provisions, as well as any rules or requirements already established related to those provisions, do not apply.

5. The substitute amendment specifies that any health benefit exchange established in this state under PPACA must be done so by legislation. The bill does not address the establishment of a health benefit exchange.

For further information, see the analysis for the bill.

(END OF INSERT A)

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but allows

related to those requirements

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636.35 Applicability if federal law found unconstitutional or repealed. **(1)** UNCONSTITUTIONAL. (a) If the Patient Protection and Affordable Care Act is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in its entirety and unenforceable in this state, and if all appeals are exhausted or the time for appeal expires, on and after the first day of the 3rd month beginning after the date on which all appeals are exhausted or the time for appeal expires s. 636.10 does not apply, any rules promulgated or requirements established under s. 636.10 are void and may not be enforced, and insurers and self-insured governmental health plans are exempt from all of the following provisions:

1. Section 625.13 (3).

2. Section 636.18.

3. Section 636.25, except for the extention of dependent coverage requirements described in s. 636.25 (1) (h) and (3) (b).

4. Chapter 625 with respect to small employer health insurance and group and blanket accident and sickness insurance offered in the individual market.

(b) If the Patient Protection and Affordable Care Act is found by a final decision of a federal court of competent jurisdiction to be unconstitutional in part and unenforceable in part in this state, and if all appeals are exhausted or the time for appeal expires, on and after the first day of the 3rd month beginning after the date on which all appeals are exhausted or the time for appeal expires all of the following apply:

1. Insurers and self-insured governmental health plans are exempt from the provisions of the Public Health Service Act referred to in this chapter that correspond to the provisions of the Patient Protection and Affordable Care Act that are found

unconstitutional, except for the extension of dependent coverage requirements described in s. 636.25 (1) (h) and (3) (b).

2. Section 636.10 does not apply with respect to the provisions described in subd. 1. from which insurers and self-insured governmental health plans are exempt, and any rules promulgated or requirements established under s. 636.10 with respect to those provisions are void and unenforceable.

(2) REPEALED. If any provision of the Public Health Service Act referred to in this chapter is repealed, on and after the date on which the repeal is effective all of the following apply:

1. Insurers and self-insured governmental health plans are exempt from the provision of the Public Health Service Act referred to in this chapter that is repealed, except for the extension of dependent coverage requirements described in s. 636.25 (1) (h) and (3) (b).

2. Section 636.10 does not apply with respect to any provision described in subd. 1. from which insurers and self-insured governmental health plans are exempt, and any rules promulgated or requirements established under s. 636.10 with respect to the provision are void and unenforceable.

(3) INAPPLICABILITY. This section does not apply after January 1, 2020.

SECTION 1. Nonstatutory provisions.

(1) ESTABLISHMENT OF HEALTH BENEFIT EXCHANGE. Any health benefit exchange established in this state under section 1311 (b) of the Patient Protection and Affordable Care Act, as defined in section 636.01 (7) of the statutes, as created by this act, must be established by legislation.

(END OF INSERT 22-17)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

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— date —

This is a preliminary draft, which will speed up turnaround if you want to make any changes.

Please review the language of proposed s. 636.35 especially carefully. Because no PPACA or Public Health Service Act (PHSA) provisions are actually cited or referred to in ch. 625, I could not think of a way to describe what in PPACA must be found unconstitutional or what in PHSA must be repealed for the ch. 625 provisions not to apply.

Note that proposed s. 636.35 (2) applies regardless of whether one or more, or all, of the provisions of PHSA that relate to PPACA are repealed, and regardless of when a repeal occurs.

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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRBs0181/P1dn
PJK:cjs:jf

September 21, 2011

This is a preliminary draft, which will speed up turnaround if you want to make any changes.

Please review the language of proposed s. 636.35 especially carefully. Because no PPACA or Public Health Service Act (PHSA) provisions are actually cited or referred to in ch. 625, I could not think of a way to describe what in PPACA must be found unconstitutional or what in PHSA must be repealed for the ch. 625 provisions not to apply.

Note that proposed s. 636.35 (2) applies regardless of whether one or more, or all, of the provisions of PHSA that relate to PPACA are repealed, and regardless of when a repeal occurs.

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